DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 03-023

2. STATE: Kentucky

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
December 1, 2003

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250-447.253

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $14 Million
b. FFY 2005 $ -0-

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A, Pages 1-7.8

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-A, Pages 1-7.7

10. SUBJECT OF AMENDMENT:
Inpatient Hospital Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Review delegated to Commissioner, Department for Medicaid Services

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME: Russ Fendley

14. TITLE: Commissioner, Department for Medicaid Services

15. DATE SUBMITTED:

16. RETURN TO:
Frances McGraw
Eligibility Policy Branch
Department for Medicaid Services
275 East Main Street 6W-C
Frankfort, Kentucky 40621

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: DEC 24 2003

18. DATE APPROVED: JAN 18 2005

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: DEC - 1 2003

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Carmen Keller

22. TITLE: DD CMSC

23. REMARKS:

(1) General Overview

Beginning April 1, 2003, the Department will pay for inpatient hospital services in general acute care hospitals under a DRG-based methodology. The methodology is based on the Medicare Prospective Payment System. Generally, all rates (operating and capital), relative weights, and payment logic have been adopted from Medicare. The relative weights have been adjusted for Medicaid average length of stay and budget neutrality.

Certain facilities and services are excluded from the DRG methodology and will continue under a prospective per diem methodology. The following will be excluded from the DRG methodology:

A. Critical access hospitals;
B. Freestanding rehabilitation hospitals;
C. Long-term care hospitals;
D. Psychiatric services in acute care hospitals;
E. Psychiatric hospitals; and
F. Transplants, other than kidney, pancreas, and cornea.

(2) Acute Care Hospital Services

A. DRG-Based Methodology

1. Participating acute care hospitals will be paid on a fully prospective per discharge basis for general acute care services. The total per discharge payment shall be the sum of an operating payment, a capital-related payment, and if applicable, a cost outlier payment.

a. Operating Payment
The operating payment will be based on a patient's DRG classification, as assigned by the Medicare DRG classification system. An operating payment will be calculated for each discharge by multiplying a hospital's operating base rate by the Medicaid-specific DRG relative weight which has been adjusted for budget neutrality.

The operating base rate for each hospital will be the Medicare national standardized amount as adjusted by Medicare using the Medicare wage index. The labor portion of the operating base rate will be multiplied by the hospital's wage index and added to the non-labor portion of the hospital's operating base rate. This amount will be adjusted by the Medicare indirect medical education operating adjustment factor. (Adjusted operating base rate X (1 + IME) The Medicare DSH operating adjustment factor will not be included in the calculation of the operating base rate.

The adjusted Medicare national standardized amount will be calculated based on the Medicare rate data published in the *Federal Register* effective on April 1, 2003. Continuing every year thereafter, the adjusted Medicare national standardized amount will be calculated based on the Medicare rate data published in the *Federal Register* effective October 1 of the year immediately preceding the universal rate year.

b. Capital-Related Payment
The capital-related payment will be calculated for each discharge by multiplying the capital-related base rate by the Medicaid-specific DRG relative weight which has been adjusted for budget neutrality. The capital-related base rate for each hospital will be the Medicare standard federal capital rate, as adjusted by Medicare for each hospital using the Medicare large urban-area adjustment factor, if applicable, the Medicare geographic adjustment factor, and the Medicare indirect medical education capital adjustment factor. The Medicare DSH capital adjustment factor will not be included in the calculation. The adjusted Medicare standard federal capital rate will be calculated based on the Medicare rate data published in the *Federal Register* effective on October 1 of the year immediately preceding the universal rate year.

c. Cost Outlier Payment
A cost outlier payment will be made for a discharge if the estimated cost of the discharge exceeds the DRG's outlier threshold of $29,000. The estimated cost of the discharge is determined by multiplying the charges for the discharge by the facility-specific Medicare cost-to-charge ratio obtained from the Medicare fiscal intermediary. Payment for a cost outlier will be eighty (80) percent of the amount that estimated costs exceed the discharge's outlier threshold.

2. Relative Weights
Kentucky Medicaid-specific DRG relative weights are based on Medicaid base year claims data. Claims are assigned to Medicare DRG classifications using the Medicare grouper. Claims data for discharges that are to be reimbursed on a per diem basis are removed from the calculation.

A statewide Medicaid arithmetic mean length-of-stay (ALOS) per discharge is determined for each DRG classification. Relative weights are calculated for each DRG by multiplying the Medicare relative weight by the ratio of the Medicaid ALOS to the Medicare ALOS multiplied by the budget neutrality (BN) factor as follows:

Medicaid relative weight =
Medicare relative weight X Medicaid ALOS/Medicare ALOS X BN factor

Medicare DRG relative weights and arithmetic mean length-of-stay will be those published in the *Federal Register* effective on October 1 of the year immediately preceding the universal rate year.

3. DRG Classifications

   Discharges will be assigned based on the Medicare grouper in effect October 1 prior to the beginning of the universal rate year except that a unique set of DRGs and relative weights have been established for Level III neonatal cases. Claims classified into DRGs 385 through 390 from Level III neonatal centers will be identified and reassigned to DRGs 685 through 690 respectively. Relative weights for these DRGs will be determined as described in 2 above using the Medicare ALOS for DRGs 385 through 390. Only Level III neonatal centers will receive payments for DRGs 685 through 690.

4. Indirect Medical Education Adjustment Factor

   An indirect medical education adjustment factor will be the same indirect medical education factor used by Medicare for Medicare rates effective on October 1 of the year immediately preceding the universal rate year. The adjustment factor will include a operating and capital component. The ratio of interns and residents to available beds in the Medicare formula will be obtained from the Medicare fiscal intermediary.

5. Direct Graduate Medical Education

   The Department will reimburse separately for the direct costs associated with a Medicare approved graduate medical education (GME) program. The Department will make annual payments calculated as follows:

   The Department will compare the hospital-specific and national average Medicare per intern and resident amounts as of October 1 immediately preceding the rate year. The hospital's number of interns and residents will be multiplied by the higher of the two amounts. The result is an estimate of total direct graduate medical education costs. The estimated total direct medical education costs will be divided by the number of total inpatient days as reported on Worksheet D, Part 1 of a hospital's most recently audited cost report to determine the average GME cost per day. The GME cost per day will be multiplied by the number of covered days, (including psychiatric days) reported in the base year claims data to determine total GME costs. Total GME costs will be multiplied by the budget neutrality factor to determine final payments.

The base year will be the calendar year ending 18 months prior to the beginning of the rebase year that begins July 1.

6. Transfers

If a patient is transferred to or from another hospital, the department will make a transfer payment if the initial admission and the transfer are determined to be medically necessary. The Department will pay the transferring hospital the average daily rate of the appropriate DRG for each covered day the patient remains in the hospital, plus one (1) day, not to exceed the full DRG payment.

The per diem will be calculated by dividing the DRG payment by the Medicaid average length-of-stay for the DRG.

The Department will pay the hospital receiving a transferred patient the full DRG payment, and if applicable, a cost outlier payment.

If a patient is transferred from an acute bed to a distinct part unit of a hospital or visa versa, the department will make a separate payment to each unit of the hospital. The claim for the acute stay will be paid the full DRG amount and the psychiatric or rehabilitation distinct part unit will receive a per diem payment based upon the number of inpatient days in the unit.

7. Post-acute Care Transfer

A transfer from an acute care hospital to a qualifying post-acute care facility for specified DRGS for services related to the diagnoses for inpatient services provided within 3 days of date of discharge will be treated as a post-acute transfer. The specified DRGs include DRG 14, 113, 209, 210, 211, 236, 263, 264, 429, and 483. Post acute-care settings include psychiatric, rehabilitation, children's, long-term acute care and cancer hospitals; skilled nursing facilities; and home health agencies. A hospital swing-bed is not considered a post-acute care setting.

Each transferring hospital will be paid a per diem rate for each day of stay. No payment will exceed the full DRG payment that would have been made if the patient had been discharged without being transferred.

DRGs 209, 210, and 211 will be paid at fifty (50) percent of the full DRG payment plus the per diem for the first day of the stay and fifty (50) percent of the per diem for the remaining days of the stay, up to the full DRG payment. DRGs 14, 113, 236, 263, 264, 429, and 483 will be paid at twice the per diem rate for the first day and the per diem rate for each following day of the stay

prior to the transfer. The per diem amount will be the full DRG divided by the statewide Medicaid average length of stay for that DRG.

8. Pre-admission Services

Outpatient services provided within three (3) calendar days of an inpatient admission for the same or related diagnosis will be included in the inpatient billing and will not be billed separately. This will not include a service furnished by a home health agency, a skilled nursing facility, hospice, or outpatient maintenance dialysis, unless the service is a diagnostic service related to an inpatient admission.

9. Readmission

An inpatient admission within fourteen (14) calendar days of discharge for the same diagnosis will be considered a readmission and will not be reimbursed as a separate admission.

10. Supplemental DRG Payments

The Department will make a supplemental payment for DRGs 385 through 390 to a hospital with a Level II neonatal intensive care unit that meets the following qualifications:

a. Is licensed for a minimum of 24 neonatal level II beds;
b. Has a minimum of 1,500 Medicaid neonatal level II patient days per year;
c. Has a gestational age lower limit of twenty-seven (27) weeks; and
d. Has a full-time perinatologist on staff.

The payment will be an additional payment of $3,775 add-on per paid discharge for each of the above DRGs.

B. Per Diem Methodology

1. Distinct Part Units in Acute Care Hospitals

The Department will pay for inpatient psychiatric services or rehabilitation services provided in a Medicare designated distinct part unit on a per diem basis beginning February 1, 2004. Payment will be determined by multiplying a hospital's psychiatric or rehabilitation per diem rate by the number of allowed patient days.

The per diem rate will be the sum of the operating per diem rate and the capital per diem rate.

The operating cost per day amounts used to determine the operating per diem rate will be calculated for each hospital by dividing its Medicaid cost basis, excluding capital costs, by the number of Medicaid patient days in the base year. The Medicaid cost basis and patient days will be based on Medicaid claims for patients with a psychiatric or rehabilitation diagnosis in the base year. The operating per diem rate will be adjusted for:

a. The price level increase from the mid-point of the base year to the mid-point of the universal rate year using the CMS Input Price Index; and
b. The change in the Medicare published wage index from the base year to the universal rate year applied to the labor portion of the rate.

The capital per diem rate will be the facility-specific capital cost per day. Depreciation on buildings and fixtures will be limited to sixty-five (65) percent of depreciation reported on the annual cost report.

The base year will be the calendar year ending 18 months prior to the beginning of the rebase year that begins July 1.

For a hospital that does not have a Medicare designated distinct part unit, psychiatric and rehabilitation services will be paid on a per diem basis at the median rate of psychiatric or rehabilitation services in acute care hospitals.

The Department will pay for psychiatric services in acute care hospitals without licensed psychiatric beds at a per diem rate equal to the median rate for all licensed psychiatric beds as described above.

2. Wage Index and Wage Area

The Department will use the wage index published by CMS in the *Federal Register* on October 1 immediately preceding the universal base rate year. The Department will assign a hospital to either the wage area in which it is physically located as originally classified by CMS for the Medicare program for the base year; or the wage area to which a hospital has been reclassified by the Medicare Geographic Classification Review Board for the base year.

The Department will not consider reclassification of a hospital to a new wage area except during a rebase period.

3. Provider Appeal Rights

An administrative review shall not be available for the following:

a. A determination of the requirement, or the proportional amount, of any budget neutrality adjustment in the prospective payment rate; or
b. The establishment of (DRGs);

c. The methodology for the classification of an inpatient discharge within each DRG; or
d. Appropriate weighting factors that reflect the relative hospital resources used with respect to discharge within each DRG.
e. The determination of the requirement or the proportional amount of any budget neutrality adjustment.

An administrative review shall be available for a calculation error in the establishment of a per diem rate.

4. Budget Neutrality Factors

In the year of implementation and subsequent rebase years, the Department will apply a budget neutrality factor to assure that estimated payments in the universal rate year will not exceed payments in the prior year, adjusted for inflation using the CMS Input Price Index and changes in utilization.

Estimated total payments for each facility under the reimbursement methodology in effect in the year prior to the universal rate year will be estimated from base year claims. Estimated total payments for each facility under the reimbursement methodology in effect in the universal rate year will be estimated from base year claims.

The budget neutrality factor is determined based on a modeling approach using base year claims. The base year will be the calendar year ending 18 months prior to the beginning of the rate year that begins on July 1. The budget neutrality factor will be calculated as follows:

a. Total payments under the reimbursement methodology in effect in the prior year are estimated using base year claims.
b. Total payments under the new reimbursement methodology are estimated using the plan year rates and relative weights, before any budget neutrality adjustments, using the same base year claims in Step 1.
c. The sum of payments for all facilities in Step 1 are compared to the sum of payments for all facilities in Step 2.
d. If the sum of payments for all facilities in Step 2 exceeds the sum of payments for all facilities in Step 1, the following rate components are reduced proportionally so that the sum of payments for all facilities in Step 2 and Step 1 are equal:
    1) DRG relative weights; and
    2) Graduate medical education payments.

The percentage reduction that is applied to the above rate components so that the sum of payments for all facilities in Step 2 is equal to the sum of payments for all facilities in Step 1 is the budget neutrality factor.

If the sum of estimated payments under the methodology used in the universal rate year exceeds the sum of adjusted estimated payments under the prior year's reimbursement methodology, the following universal rate year reimbursement components will be adjusted to achieve budget neutrality:

(3) Reimbursement Updating Procedures

The Department will adjust per discharge base rates and psychiatric per diem rates annually beginning July 1, 2004. The department will adjust DRG rates on July 1 using the Medicare DRG base rate in effect October 1 of the preceding year as published in the *Federal Register.*

The Department will adjust psychiatric per diem rates by inflating the psychiatric operating per diem from the mid-point of the previous universal rate year to the mid-point of the current universal rate year using the CMS Input Price Index. The psychiatric capital per diem rate will not be adjusted.

DRG relative weights, and other applicable components (Graduate Medical Education, cost-to-charge ratios, outlier thresholds) of the payment rates will be updated every three (3) years using the most recent audited cost report and Medicare rate data available to the department.

(4) Use of a Universal Rate Year
Except for the first year of the DRG system, a universal rate year will be established as July 1 through June 30 of each year to coincide with the state fiscal year. In the first year of the DRG system, the universal rate year will be the fifteen-(15) month period from April 1, 2003 through June 30, 2004. A hospital will not be required to change its fiscal year to conform to the universal rate year.

(5) Reimbursement for Out-of-state Hospitals

An acute care out-of-state hospital will be reimbursed for an inpatient acute care service and an inpatient rehabilitation service in an acute care hospital on a fully prospective per discharge basis for the universal rate year beginning on or after April 1, 2003. The total per discharge reimbursement will be the sum of an operating payment, a capital-related payment, and, if applicable, a cost outlier payment.

A. The operating payment will be based on the patient's Medicare DRG classification. The operating payment will be calculated for each discharge

by multiplying a hospital's operating base rate by the Kentucky-specific DRG relative weight. A hospital's operating base rate will be the Medicare national standardized amount, as adjusted by Medicare for each hospital using the Medicare wage index. Amounts for out-of-state providers will not include the Medicare DSH operating adjustment factor or the Medicare indirect medical education operating adjustment factor.

B. The capital-related payment will be made on a per discharge basis. The capital-related payment will be calculated for each discharge by multiplying a hospital's capital-related base rate by the Kentucky-specific DRG relative weight. A hospital's capital-related base rate will be the Medicare federal capital rate, as adjusted by Medicare for each hospital using the Medicare large urban-area adjustment factor when applicable and the Medicare geographic adjustment factor as published in the Federal Register. Amounts for out-of-state providers will not include the Medicare DSH capital adjustment factor or the Medicare indirect medical education capital adjustment factor.

C. A cost outlier payment will be made by using the same method and criteria used to determine the payment for in-state claims.

D. An acute care out-of-state hospital will be reimbursed for an inpatient psychiatric service on a fully prospective per diem basis for the universal rate year beginning on or after April 1, 2003. Reimbursement for an inpatient psychiatric service will be determined by multiplying a hospital's psychiatric per diem rate by the number of allowed patient days.

E. A psychiatric per diem rate will be the sum of a psychiatric operating per diem rate and a psychiatric capital per diem rate. The psychiatric operating per diem rate will be the median operating cost per day, excluding graduate medical education, for all acute care in-state hospitals that have licensed psychiatric beds. The psychiatric capital per diem rate will be the median psychiatric capital per diem rate for all acute care in-state hospitals that have licensed psychiatric beds.

(6) Critical Access Hospitals

The Department pays for inpatient services provided by critical access hospitals through an interim per diem rate as established by the Centers for Medicare and Medicaid Services (CMS) for the Medicare Program. The effective date of a rate will be the same as used by the Medicare Program. Critical access hospitals will be required to submit an annual Medicare/Medicaid cost report. Payments will be settled to actual costs based on final audited cost reports.
Total payments made to critical access hospital will be subject to the payment limitation in 42 CFR 447.271.